Point of Service

Employee/Member Enrollment or Change Application

CareFirst BlueCross BlueShield

1 APPLICANT INFORMATION

EMPLOYEE/MEMBER/APPLICANT LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NUMBER
			__ __ __ / __ __ /__ __ __ __

STREET ADDRESS	CITY	STATE	ZIP

SEX	DATE OF BIRTH	HOME PHONE	EMPLOYMENT STATUS

2 MEDICARE / TEFRA INFORMATION (to be completed if applicable)

ARE YOU ELIGIBLE FOR MEDICARE? ☐ YES ☐ NO	IF YES:	MEDICARE NUMBER __ __ __ – __ __ – __ __ __ __ – __ __	HOSP. EFF DATE (PART A) __ __/__ __/__ __	MED. EFF DATE (PART B) __ __/__ __/__ __
SPOUSE? ☐ YES ☐ NO	IF YES:	MEDICARE NUMBER __ __ __ – __ __ – __ __ __ __ – __ __	HOSP. EFF DATE (PART A) __ __/__ __/__ __	MED. EFF DATE (PART B) __ __/__ __/__ __
CHILD? ☐ YES ☐ NO	IF YES:	MEDICARE NUMBER __ __ __ – __ __ – __ __ __ __ – __ __	HOSP. EFF DATE (PART A) __ __/__ __/__ __	MED. EFF DATE (PART B) __ __/__ __/__ __

☐ **CHECK HERE FOR TEFRA IF ALL OF THE FOLLOWING APPLY:**

- YOU AND YOUR SPOUSE ARE 65 OR OLDER AND ELIGIBLE FOR MEDICARE
- YOU ARE ACTIVELY EMPLOYED
- YOU ARE CONTINUING GROUP COVERAGE WITH BLUE CROSS AND BLUE SHIELD AS PRIMARY CARRIER
- YOUR EMPLOYER MEETS TEFRA REQUIREMENTS*

I AM APPLYING FOR ☐ Self ☐ Spouse

*** IF UNKNOWN, YOUR PERSONNEL DEPARTMENT SHOULD BE ABLE TO ASSIST YOU WITH THIS INFORMATION.**

3 SPOUSE/CHILD PRIMARY CARE PHYSICIAN INFORMATION

Please list all members to be covered. Choose a PCP for each member.

LIST ELIGIBLE SPOUSE AND / OR CHILD TO BE COVERED LAST NAME / FIRST / M.I. RELATIONSHIP		SEX	DATE OF BIRTH	SOCIAL SECURITY NUMBER	EXISTING PATIENT?	PCP ID NUMBER	PRIMARY CARE PHYSICIAN
	EMPLOYEE/ APPLICANT				☐ Y ☐ N		
	SPOUSE				☐ Y ☐ N		
	CHILD				☐ Y ☐ N		
	CHILD				☐ Y ☐ N		
	CHILD				☐ Y ☐ N		
	CHILD				☐ Y ☐ N		

FULL TIME (12 CREDIT HRS.) UNMARRIED COLLEGE STUDENT SCHOOL GRAD DATE

NAME:

FULL TIME (12 CREDIT HRS.) UNMARRIED COLLEGE STUDENT SCHOOL GRAD DATE

NAME:

4 OTHER HEALTH INSURANCE INFORMATION (to be completed if applicable)

NOTE: THIS INFORMATION IS SUBJECT TO VERIFICATION. FAILURE TO COMPLETE THIS SECTION MAY DELAY CLAIMS PAYMENT.

ARE YOU, YOUR SPOUSE, OR ANY LISTED CHILDREN COVERED BY ANY OTHER HEALTH INSURANCE OR ANOTHER BLUE CROSS AND BLUE SHIELD PLAN? ☐ YES ☐ NO

IF YES:

NAME OF POLICY HOLDER — POLICY NUMBER

INSURANCE COMPANY — CITY AND STATE

DOES THIS POLICY COVER YOU? ☐ YES ☐ NO
YOUR SPOUSE? ☐ YES ☐ NO
YOUR CHILDREN? ☐ YES ☐ NO

5 CHILD INFORMATION

Child—a person who is unmarried and 19 years of age or younger unless a full-time student, or over 19 years and is incapable of self-support because of mental or physical incapacity; and who receives 50% or more financial support from the Applicant; and is (1) the Applicant's child; or (2) the Applicant's spouse's child; or (3) is legally adopted by the Applicant (including the first day of assumption of custody pending adoption); or (4) a

READ CAREFULLY. THIS APPLICATION, WHEN ACCEPTED, IS PART OF THE CONTRACT.

I hereby apply, on behalf of myself and each dependent listed above for the health coverage indicated. If this application is accepted, coverage will be provided according to the terms and conditions of the health care contract between CareFirst Blue Cross and Blue Shield and my employer. I agree to be bound by that health care contract of which this application will become part. I also agree to pay current and future charges for the health care coverage provided in excess of any employer contribution.

I hereby authorize any physician, hospital, or other provider of service to furnish any information, reports, or copies of records, related to care or services rendered to me or any of the dependents listed above to CareFirst Blue Cross and Blue Shield. Such information is to be held confidential.

I have carefully read this application and agree to its terms. The recorded answers on this application are, to the best of my knowledge and belief, full, complete, and true as of this date. I also understand that failure to enter full, complete and true updated information may result in the denial of benefits, and voiding of any membership issued. I further certify that I am the spouse, parent or legal guardian of the dependents listed above; they are dependent upon me for primary support as defined by the IRS.

EMPLOYEE'S/MEMBER'S/APPLICANT'S SIGNATURE DATE

SPOUSE'S SIGNATURE DATE

PLEASE RETURN COMPLETED APPLICATION PAGES 1 THRU 3 TO YOUR EMPLOYER AND RETAIN PAGE 4 FOR YOUR RECORDS